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IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 76-811

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA,
Petitioner,

v.

ALLAN BAKKE, *Respondent.*

On Writ of Certiorari to the Supreme Court of California

BRIEF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AMICUS CURIAE

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OPINION BELOW

The opinion of the California Supreme Court is reported at 18 Cal.3d 34, 132 Cal.Rptr. 680, 553 P.2d 1152 and is reprinted as Appendix A to the Petition for a Writ of Certiorari. The modification of the California Supreme Court's opinion is reported at 18 Cal.3d 252b and is reprinted as Appendix C to the Petition for a Writ of Certiorari.

JURISDICTION

The jurisdiction of this Court rests on 28 U.S.C. § 1257(3). Certiorari was granted on 22 February 1977.

QUESTION PRESENTED

When only a small fraction of thousands of applicants can be admitted, does the Equal Protection Clause forbid a state university medical school faculty from voluntarily seeking to counteract effects of generations of pervasive discrimination against discrete and insular minorities by establishing a limited special admissions program that increases opportunities for well-qualified members of such racial and ethnic minorities?

CONSTITUTIONAL PROVISION

The Fourteenth Amendment to the Constitution of the United States provides:

> ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

CONSENT TO FILE[1]

This Amicus Curiae brief is being filed with the consent of all parties to the proceeding.

INTEREST OF THE AMICUS CURIAE

The Association of American Medical Colleges ("AAMC") is a nonprofit corporation organized under the

[1] Letters of consent of all parties to the case have been filed with the Clerk of the Court.

laws of the State of Illinois with national headquarters in Washington, D.C. The Association consists of all 118 accredited United States medical schools, 400 teaching hospitals affiliated with medical schools for the purpose of education, and 60 academic societies having medical education as a primary interest. The Association was first organized in 1876 and has functioned continuously since 1890.

The purpose of the Association is the advancement of medical education and the nation's health. To this end, the AAMC provides a means of national expression on matters of concern in medical education, particularly on matters which affect the ability of its member institutions to maintain programs of academic excellence or to respond appropriately to societal needs. The medical schools of this country share with other professional schools and institutions of higher learning a proud tradition of dedication to scholarship and public service. Society has wisely fostered this tradition by erecting guarantees of academic freedom and by delegating to the academic community substantial autonomy in the management of the internal affairs of these institutions.

Two of the most important social challenges facing our country are of particular relevance to medical schools: equity of access to higher education and the learned professions, and equity of access to quality medical care. In response to these challenges, medical schools have reexamined the traditional criteria in the establishment and implementation of admissions policies.

The Association strongly supports the efforts of its member schools to provide opportunities for obtaining a medical education to applicants of diverse racial and ethnic backgrounds who are qualified to perform successfully as medical students. The Association also believes that a serious national need may be fulfilled by educating those qualified students who will be most likely to provide medical care

in urban ghettos, rural areas, and other sections of the United States that presently are underserved by professionals adequately trained to provide such care.

Although each school differs in the form of its approach to the problem of special admissions, almost all medical schools currently recognize the need to take race into account in evaluating the capabilities of disadvantaged minority applicants. Medical schools have a crucial interest in maintaining the diversity among students which contributes to the quality of education, and in guaranteeing that the admissions process will be flexible enough to permit personalized evaluation.

The AAMC is a national spokesman for medical education and a focal point for information about medical schools and the process of medical education. As such, its interest in this case is based on the schools' responsibilities for selecting students and maintaining educational quality. The Court's decision in this case will have a profound impact on the quality of medical education, the composition of the medical profession, and the accessibility of medical care to all segments of our population.

Consistent with its national perspective, the Amicus Curiae will leave the particular facts of the case to the briefs of the parties and will concentrate on those questions which affect all of medical education.

STATEMENT OF THE SITUATION IN MEDICAL EDUCATION

In General

Last year, 42,155 applicants to medical school competed for 15,774 positions. Although this represents nearly a doubling of the size of the first-year class from the 8,173 who entered in 1959, the number of applicants has nearly

tripled during the same period. Thus, competition for limited places in medical school has become increasingly more intense. Indeed, it is not unusual for a single school to have several thousand applications for one hundred first-year places, as the University of California, Davis School of Medicine did in this case. It is generally recognized that the majority of these applicants are qualified *to study* medicine, although only a small fraction of them can be admitted at any given school.

In the face of this pressure for admission, the primary purpose of the medical school admissions process is to select from among applicants deemed qualified to study medicine those who, in the judgment of a duly constituted admissions committee, will become high-quality physicians most likely to contribute to the needs of the nation or the state for medical care. This purpose necessarily implies that some subjective judgments must be made in assessing the needs of the state and the likelihood that one individual, more than another also qualified for medical study, will tend to serve those needs. Many criteria are applied to aid in this difficult evaluation process, including relevant personal characteristics. Most medical schools believe that race is a very relevant personal characteristic which should be considered with other criteria to provide insight into the kind of physician the applicant will become.

Medical schools have long used a variety of subjective measurement tools in evaluating applicants. Realizing that undergraduate grade point averages (GPAs) and Medical College Admission Test (MCAT) scores alone are insufficient to predict more than the ability to study medicine, admissions committees rely on personal recommendations, personal interviews, commitment to service, and a variety of other biographical characteristics to determine which academically qualified applicants will make the best doctors. For example, as reported in Association of American Medi-

cal Colleges, *Medical School Admissions Requirements 1977-78*, at 29 (1976), 110 of the 114 schools reporting indicated that they had held personal interviews with 90-100 percent of the applicants who were ultimately accepted during the previous year. Only two schools reported that less than half of the applicants ultimately accepted were interviewed. Thus, admissions decisions properly include an assessment of personal characteristics.

The application of these subjective criteria is reflected by the following statistics. Of the 33,762 white applicants to medical school for the 1976-77 entering class, 10,301 had undergraduate GPAs of 3.30 or better (on a 4.0 scale) *and* MCAT science scores of 600 or better (on a 205-795 scale). Yet, 31 percent of these applicants (3,194 individuals) were not accepted to any medical school, while 882 white applicants whose grades and MCAT science scores were *both* lower than these levels were accepted. (Derived from data presented in B. Waldman, *Economic and Racial Disadvantage as Reflected in Traditional Medical School Selection Factors: A Study of 1976 Applicants to U.S. Medical Schools*, Association of American Medical College (1977) (Tables A-12, A-16). Therefore, it is clear that admissions committees have looked beyond grades and test scores in selecting students to be admitted.

The MCAT examination itself has recently undergone extensive revision after 26 years of administration in essentially the same form. The test was originally developed to assist admissions committees in reducing the attrition rate among medical students by providing a standardized measurement of knowledge and ability in order to predict success in the basic science curriculum, which usually comprises the first two years of medical school. Since the introduction of the MCAT, the attrition rate has decreased substantially. The "New MCAT," first administered in April 1977, has expanded the measurement of ability in the sciences and now also assesses the applicant's problem-solving skills. At the request of the medical schools, the

Association is exploring the development of additional instruments to measure personal qualities deemed necessary for the practice of medicine. Seven of these qualities have been identified by AAMC researchers for study: compassion, interprofessional relations, coping capability, sensitivity in interpersonal relations, decision-making capacity, staying power, and realistic self-appraisal.

As the number of applicants to medical school increased dramatically in the late 1960's and early 1970's (*see* Datagram, 50 J. Med. Educ. 912 (1975)), the mean level of academic ability and achievement of the applicants increased sharply. Superior students who previously might have pursued advanced study in the physical sciences, engineering, or liberal arts responded to the economic insecurity of those fields by turning in large numbers to law and medicine. The mean MCAT science score of accepted students increased from 516 in 1957 to 615 in 1975. The mean MCAT quantitative ability score increased from 517 to 620 during the same period. *Medical Education in the United States 1975-76*, 236 *J.A.M.A.* 2949, 2963 (1976). Thus, because of the larger pool of academically highly qualified students, medical schools have raised their admissions standards well beyond the minimum level necessary to ensure completion of the course of study leading to the M.D. degree.

For a more exhaustive review of the medical school admissions process, *see generally* J. Cuca, L. Sakakeeny, and D. Johnson, *The Medical School Admissions Process: A Review of the Literature 1955-76*, Association of American Medical Colleges (1976); T. Gordon, *Descriptive Study of Medical School Applicants 1975-76*, Association of American Medical Colleges (1977).

Medical Education of Minority Students

Until very recently, the medical education of black students was largely accomplished by only two institutions—Howard University in Washington, D.C., and Meharry

Medical College in Nashville, Tennessee. As recently as 1963-64, only 173 black students were enrolled in the predominantly white medical schools; Howard and Meharry then accounted for 75.8 percent of all black medical students. C. Odegaard, *Minorities in Medicine: From Receptive Passivity to Positive Action 1966-76,* at 19, Josiah Macy, Jr. Foundation (1977). Particularly as a result of recruitment efforts and special admissions programs by the predominantly white medical schools, black enrollment increased from 783 (2.2 percent of total enrollment) in 1968-69 to 3,456 (6.2 percent of total enrollment) in 1975-76. Howard and Meharry by then accounted for only 19 percent of all first-year black students. C. Odegaard, *supra* at 29-32.

This historic limitation of opportunity was reflected in the lack of minority physicians. In 1970, only 2.2 percent of U.S. physicians were black, the same proportion as in 1950. This compared with black representation in the U.S. population of 11 percent. C. Odegaard, *supra* at 29. Furthermore, a 1972 analysis showed that the black population was increasing faster than the number of black physicians, and that the ratio of black physicians to the black population was lower in 1972 than in 1942. Thompson, *Curbing the Black Physician Manpower Shortage,* 49 J. Med. Educ. 944 (1974). Thus, in the absence of affirmative efforts to recruit and admit qualified minority applicants, the medical profession remained an almost exclusively white domain long after this Court's classic opening of professional education in *Sweatt* v. *Painter,* 339 U.S. 629 (1950).

It must be clearly understood that many of the minority applicants who were and would still be excluded from medical school in the absence of special admissions programs are academically qualified to study medicine. But their otherwise acceptable academic qualifications pale in comparison with the much higher academic qualifications of the very large and highly competitive pool of white ap-

plicants. For example, as noted above, the mean MCAT science and quantitative ability scores for all applicants *accepted* in 1957-58 were 516 and 517 respectively. In 1975-76, these mean scores for all Black Americans accepted were 500 and 515 respectively. Other minority acceptees scored slightly higher. But 1975-76 white acceptees averaged 627 and 629 on these two scores and the whole pool of white applicants averaged 580 and 594 respectively. Thus, the qualified minority applicant, who is perhaps just catching up to the level of educational ability and achievement attained by the qualified white applicant of twenty years ago, cannot compete with the even more highly academically qualified white applicants of today. *See* T. Gordon, *supra* at 70.

Retention rates also demonstrate that minority students admitted under special admissions programs are academically qualified to study medicine. An in-depth study of minority students entering medical school between 1970 and 1972 indicated that academically related attrition after the first year of medical school, when most academic difficulties are encountered, was only 2.6 percent among blacks in 1970 and 4.4 percent in 1971. All other minority groups reported even lower attrition rates. The study concluded:

> The most encouraging fact to emerge in the analysis of the retention/attrition data was that all the racial groups entering in 1970 and 1971 had retention figures higher than 91 percent at the end of their first year in medical school. Compared with other graduate and professional schools, this is very favorable. Moreover, it should dispel the rumor of exceptionally high attrition among minority students.
>
> For the two classes studied, black students had slightly lower retention rates than did whites or most of the other minorities. For the 1970 and 1971 entering classes, the retention rates for blacks were 95 percent and 91 percent respectively, as compared with 98 percent and 97 percent for white students. These

> rates for blacks are similar to the national rates of a decade ago before the applicant pool was expanded and before maximum efforts were made to improve retention rates. Johnson, Smith, and Tarnoff, *Recruitment and Progress of Minority Medical School Entrants 1970-1972,* 50 J. Med. Educ. 713, 738 (1975) (footnotes omitted).

In addition to demonstrating the ability to complete the medical school curriculum, minority students admitted under special admissions programs have performed scholastically at or near the level of regularly admitted students. *See, e.g.,* Simon and Covell, *Performance of Medical Students Admitted Via Regular and Admission-Variance Routes,* 50 J. Med. Educ. 237 (1975).

ARGUMENT

THE EQUAL PROTECTION CLAUSE DOES NOT PROHIBIT THE LIMITED VOLUNTARY USE OF SPECIAL MINORITY ADMISSIONS PROGRAMS WHICH INCREASE OPPORTUNITIES FOR EDUCATIONALLY DISADVANTAGED MEMBERS OF MINORITY GROUPS UNDERREPRESENTED IN THE MEDICAL PROFESSION.

This Court has delineated several tests under which state action is to be measured for consistency with the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. *Compare Williamson* v. *Lee Optical Co.,* 348 U.S. 483 (1955) (rational relation test) *with Korematsu* v. *United States,* 323 U.S. 214 (1944) (compelling interest test) *and Dunn* v. *Blumstein,* 405 U.S. 330 (1972) (intermediate balancing test). Yet this Court has never before articulated which standard of review should apply to carefully limited and voluntary programs which increase opportunities for disadvantaged minority group members.

Distinguished commentators disagree as to which standard of review should apply. *Compare* Ely, *The Constitutionality of Reverse Racial Discrimination,* 41 U. Chi. L. Rev. 723, 727 (1974) (advocating application of the rational relation test) *with* O'Neil, *Preferential Admissions: Equalizing the Access of Minority Groups to Higher Education,* 80 Yale L.J. 699, 710 (1971) (advocating strict scrutiny). Regardless of which previously enunciated constitutional test the Court chooses to apply, and unless this Court so deviates from precedent as to establish a per se test of unconstitutionality, special minority admissions programs in medical schools must be upheld.

These programs meet the most severe tests which this Court has previously announced. They advance several distinct compelling state and national interests which can be accomplished only by the use of special admissions programs based on racial/ethnic minority status. Furthermore, these programs are remedial in nature; this Court has consistently and correctly recognized that programs remedying the effects of past discrimination often must take race into account. *See, e.g., North Carolina State Board of Education* v. *Swann,* 402 U.S. 43, 46 (1971):

> Just as the race of students must be considered in determining whether a constitutional violation has occurred, so also must race be considered in formulating a remedy. To forbid, at this stage, all assignments made on the basis of race would deprive school authorities of the one tool absolutely essential to fulfillment of their constitutional obligation to eliminate existing dual school systems.

A. Special Minority Admissions Programs Are Remedial and Are Not Primarily Preferential.

Minority applicants to medical schools cannot compete fairly with white applicants when prior educational achievement is the predominant criterion for admission. As demonstrated graphically in B. Waldman, *Economic and Racial Disadvantage as Reflected in Traditional Medical School Selection Factors: A Study of 1976 Applicants to U.S. Medical Schools,* Association of American Medical

Colleges (1977), the GPAs and MCAT scores of racial/ethnic minorities as a class reflect a level of educational disadvantage which cannot be attributed to economic status. Lower income whites do not share this disadvantage as a class. Waldman, *supra* at 7. Rather, this disadvantage results from generations of slavery, segregation, and purposeful discrimination, the effects of which permeate the environment in which minority students are raised. This educational disadvantage is attributable to the poorer quality of public schools where minority students have traditionally begun their education; to the shortage of professional role models with whom aspiring minority students can identify; to a home life in which parents who have been denied opportunity for education and advancement feel the hopelessness of their situation and may fail to encourage their children to prepare for higher education; and to the general lack of expectation that the minority student will attain professional status.

The current lack of representation of minorities in the medical profession contributes to the perpetuation of this cycle, in which the lack of real hope and real opportunity breeds disinterest and lower achievement. The breaking of this cycle by providing special remedial programs over the short term might make it possible one day to eliminate these manifestations of past discrimination and eradicate "educational disadvantage." *See generally* W. Sedlacek and G. Brooks, *Racism in American Education: A Model for Change* (1976).

Given the pervasive past discrimination which has in some way touched the life of almost every minority student in our white society, it certainly cannot be unconstitutional for a public institution of higher education to try to alleviate the effects of this inequity by deciding that minority students should be evaluated competitively only with one another. This is a remedial measure of the most basic kind. As noted above, *see* p. 9 *infra*, minority performance on the

MCAT is approximately equal to white performance of twenty years ago. With the increased opportunities provided by special minority admissions programs, perhaps the vicious cycle of hopelessness can be broken and this gap in academic achievement closed.

B. Special Minority Admissions Programs Enable Admissions Committees to Assess Properly the Credentials of Minority Applicants.

The major task confronting the admissions committee is to predict an applicant's success as a medical student and as a physician. In order to accomplish this, the committee utilizes a great deal of information about the applicant, including grades, MCAT scores, recommendations, interview results, extra-curricular activities, community service, and autobiographical sketches. The committee must then decide which pieces of information on each applicant best predict that individual's potential for success. If the criteria which best predict success for one class of applicants differ from the criteria which best predict success for another class of applicants, then the committee must evaluate these two groups of applicants separately and with differing measures. There is strong evidence indicating that minority applicants cannot be accurately evaluated according to the same criteria usually applied to whites. *See, e.g.,* W. Sedlacek and G. Brooks, *Predictors of Academic Success for University Students in Special Programs,* University of Maryland Cultural Study Center Research Report No. 4-72 (1972).

More specifically, at least one major study concludes that students should be admitted to institutions of higher education by race/sex subgroups because (1) studies show no correlation between grades and test scores and subsequent academic performance for blacks; (2) if traditional "predictors" are used, optimum validity is achieved by separate equations or "cut-off" scores for each race/sex subgroup; and (3) certain background, interests, attitudes, and

motivations are useful in predicting the success of minority students but not of white students. W. Sedlacek, *Should Higher Education Students Be Admitted Differentially By Race and Sex: The Evidence,* University of Maryland Cultural Study Center Research Report No. 5-75 (1975).

Medical school studies indicate that while traditional criteria (GPAs, MCAT scores) have some predictive value for minority medical students, minority students often succeed where whites with comparable scores do not. In fact, one study shows that black medical students promoted without interruption through the first two years of medical school had lower mean MCAT scores than did white students who had been dismissed for academic reasons during the same period. R. Feitz, *The MCAT and Success in Medical School* (paper presented to the American Educational Research Association, 1974); *see also* Evans, et al., *Traditional Criteria as Predictors of Minority Student Success in Medical School,* 50 J. Med. Educ. 934 (1975); Simon and Covell, *supra.*

Several non-cognitive variables which particularly tend to predict academic success of minority students have been identified. These include positive self-concept, an ability to understand and deal with racism, realistic self-appraisal, a willingness to defer immediate gratification for long-range goals, the availability of a strong support person, successful leadership experience within the racial/cultural environment, and demonstrated community service. W. Sedlacek and G. Brooks, *Racism in American Education: A Model for Change* 55-59 (1976). The Association of American Medical Colleges strongly advocates the use of these criteria as predictors of minority student success and has conducted successful workshops across the country to instruct admissions officers on their proper application to individual students.

It is within the particular competence of the admissions committee to decide if the goal of accurately assessing applicants' qualifications requires the use of different criteria

according to race. Equalizing the availability of information and improving the evaluation process itself is a compelling interest which implies no invidious discrimination against any group. The use of a bifurcated admissions process in which a specially qualified committee applies different and possibly better predictive criteria to minority applicants, therefore, is not inconsistent with the Equal Protection Clause.

C. Special Minority Admissions Programs Improve the Quality of Education Received by All Medical Students.

Admission of minority students to medical school classes and ultimately to the medical profession provides a diversity among those groups which is beneficial to each of them as well as to the public they will serve. Exposure of the traditional medical student to the different problems and values of those from a minority background makes all such professionals better able to provide medical care to minority patients. Similar exposure to patients of different racial and cultural backgrounds first occurs during clinical training received by students in the third and fourth years of medical school. The educational value of clinical training is greatly enhanced by the bedside presence of a heterogeneous class, able to relate to this mix of patients from the perspectives of their differing social, economic, and cultural backgrounds.

Ensuring this diversity requires that the admissions committee affirmatively consider the racial and ethnic backgrounds of applicants, admitting students from atypical backgrounds in numbers large enough to produce the desired effect.

Protecting class diversity to improve the quality of education and to integrate the profession is a compelling interest. Furthermore, this is not an invidious use of race, since it only serves to ensure that minimal representation of racial/ethnic minorities is preserved.

D. Special Minority Admissions Programs Help Meet the Nation's Need for Physicians to Serve Presently Underserved Segments of the Population.

The accessibility of medical care to all Americans is a continuing concern of government at the national, regional, and statewide levels. Numerous recent studies have recognized that the geographic and specialty distribution of physicians is the key to improving accessibility of medical care. *See, e.g.,* Institute of Medicine, *Medicare/Medicaid Reimbursement Policies* 51-75, National Academy of Sciences (1976). Government initiatives aimed at enticing more physicians into underserved rural and urban ghetto areas (*e.g.,* establishment of the National Health Service Corps) and encouraging more medical school graduates to enter the primary care specialties (*e.g.,* special project grants to establish residencies in family medicine) have become common in the 1970's. Producing physicians who will serve presently underserved segments of the population or who will practice primary care medicine is a compelling state and national interest.

Minority physicians tend to fulfill these interests to a greater extent than do white physicians. This observation is made in a major study conducted by the National Planning Association, which reaches four conclusions:

1. Young minority physicians are locating at unprecedented rates in the South where large rural and urban minority populations have traditionally been medically underserved.
2. Minority physicians are more likely than others to settle in large cities with concentrations of low-income populations.
3. Minority physicians are more likely than others to engage in primary care practice.
4. Minority physicians are more likely than other graduates of American medical schools to practice in large city public hospitals, neighborhood health centers, and other public institutions responsible for providing medical services to low-income, typically underserved populations.

Koleda and Craig, *Minority Physician Practice Patterns and Access to Health Care Services,* National Planning Association Newsletter "Looking Ahead," Vol. 2, No. 6 (1976).

These findings are supported by a Howard University Medical Alumni Survey, which reports a sampling of alumni (81 percent of whom were black) showing that: (1) two-thirds of their patient care was provided to blacks; (2) 41 percent of their patient care was provided to the "very poor" or the "not very well off;" (3) 32 percent practiced or planned to practice in the inner city; and (4) 45 percent had chosen primary care specialties. *Highlights of Medical Alumni Survey,* 21 MedicAnnales 4 (1977). These percentages greatly exceed the frequency at which all physicians are currently serving these needs.

These analyses support AAMC's belief that the purpose of medical schools—to educate qualified individuals who will best serve the country's compelling need for medically trained professionals—will be significantly advanced by special admissions programs for minorities.

E. Medical Schools Can Address These Compelling Interests Only By Establishing Some Form of Special Minority Admissions Program.

The critical error in the opinion below was the California Supreme Court's assumption that these compelling interests could be achieved in a less intrusive manner without consideration of race. Specifically, the majority opinion suggests that increased class size or special treatment of "disadvantaged" applicants of all races may address these concerns. *Bakke* v. *Regents of the University of Cali-*

fornia, 18 Cal.3d 34, 55, 132 Cal. Rptr. 680, 694, 553 P.2d 1152, 1166 (1976). This assumption is simply not correct.

Increasing the class size to permit more minorities to enter medical school will add very few, if any, minority students to the class in the absence of a special admissions program. Furthermore, increasing class size often requires additional facilities and faculty. The cost of such expansion could be prohibitive. An AAMC study conducted in the early 1970's found the annual per student cost of medical education to be between $16,000 and $26,000. *Undergraduate Medical Education: Elements, Objectives, Costs,* 49 J. Med. Educ. 97 (1974).

Without special admissions programs it is not unrealistic to assume that minority enrollments could return to the distressingly low levels of the early 1960's. This would mean a drop from the present level of 8.2 percent enrollment of underrepresented minorities (defined as Black Americans, American Indians, Mexican Americans, and mainland Puerto Ricans) to slightly over 2 percent.

The California Supreme Court's suggestion of applying special admissions programs to "disadvantaged" students ignores the fact that factors associated with race are what lead to educational disadvantage. This is dramatically shown in B. Waldman, *Economic and Racial Disadvantage as Reflected in Traditional Medical School Selection Factors: A Study of 1976 Applicants to U.S. Medical Schools,* Association of American Medical Colleges (1977). This study reports that MCAT scores and GPAs vary only slightly according to parental income, within the same racial/ethnic grouping. But MCAT scores and GPAs vary substantially according to race, within the same income grouping. Waldman at 7. The study concludes that the variety of factors associated with race confers a far greater level of educational disadvantage than does lower economic status alone. Waldman at 5.

The Waldman study also presents models which show that admission based solely on traditional numerical criteria would not result in a disproportionate exclusion of lower income whites, but would result in a disproportionate exclusion of minority applicants regardless of income level. Waldman at 6-8. Thus, the schools could not justifiably consider low family income levels alone as conferring educational disadvantage and qualifying an applicant for special consideration.

How then should an admissions committee determine which applicants are educationally disadvantaged? The variety of factors discussed at page 12 *infra* must be considered at the very least. But an admissions committee has neither the time nor the resources to investigate the home life and the elementary education of each applicant. Furthermore, it seems indisputable from the data presented in Waldman and from the Sedlacek studies cited at pages 13-14 *infra*, that the disadvantage to which the California Supreme Court refers is centered in race and results from generations of pervasive discrimination in public education and in social and professional institutions.

Since the educational disadvantage which the admissions committee must recognize in order to evaluate an applicant properly is based on factors inseparable from race, cognizance of race in the admissions process is a legitimate duty of the committee, is necessary to address the compelling interests, and is constitutional under the Equal Protection Clause.

CONCLUSION

This Court should not prohibit state medical schools from voluntarily seeking to guarantee diversity in the classroom and the profession, to ensure proper assessment of applicants' potential abilities, and to increase the availability of medical services by operating limited special minority admissions programs.

The judgment below should be reversed.

Respectfully submitted,

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